22nd International AIDS Conference
Amsterdam, July 23-27, 2018

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

Reducing Health Worker Stigma and Discrimination Is Critical to Reaching 90-90-90 Targets and Is Possible: Evaluation Results of a Whole-Facility Approach in Ghana

#PEPFAR15

Authors: Laura Nyblade,[1] Nii Akwei Addo,[2] Kyeremeh Atuahene,[3] Emma Gyamera,[2] Christin Stewart,[1] Suzie Jacinthe,[4] Emmanuel Esandoh,[4] Nabil Alsoufi,[4] Richard Vormawor,[2] and John Kraemer[5]
Affiliation: [1]RTI International, [2]Educational Assessment Resource Center, [3]Ghana AIDS Commission, [4]U.S. Agency for International Development, [5]Georgetown University

Background

Achieving "90-90-90" targets requires addressing structural factors to reach people who are hidden due to stigma and discrimination from their HIV, key population, or other marked status. Stigma and discrimination in health facilities are particularly detrimental, yet their reduction is not a standard or scaled practice. Lack of evaluated stigma and discrimination-reduction interventions is a contributing factor. In response, we developed and tested a whole-facility approach to stigma reduction in Ghana.

"The training improved staff interaction – we got to know staff from other departments and doing different jobs. Because of the way the training mixed staff – doctors worked with cleaners, nurses worked [with] security and so forth. Now we have improved patient referral within our facility. Because we now know each other we can call each other easily to ask for help for a specific client."

– Champion team member/pharmacist

Billboard outside of Tema General Hospital discouraging HIV-related stigma and discrimination.

Intervention

The HP+ whole-facility approach to stigma reduction in Ghana built on global best practices, adapted to the Ghanaian context and tailored in response to baseline evidence. Baseline data played a key role in quantifying and specifying the challenge of stigma and discrimination in each facility and catalyzing action. Other key elements of the approach included:

- A focus on building capacity for facility-owned and facility-driven responses, including:
  - Deliberate and continual engagement of senior management:
    - Participatory baseline data dissemination.
    - Data validation, problem identification, and action planning.
  - Built capacity within facilities to lead stigma and discrimination-reduction by:
    - Training facility staff and clients as facilitators over five-days who then returned to their facilities to train their peers.
    - Working with facility management to form and empower champion teams within facilities—that were provided $5,000 seed grants—to work collaboratively to develop, prioritize, and support stigma and discrimination-reduction activities.
- Using the whole-facility approach, all levels of staff across departments participated in two days of on-site stigma- and discrimination-reduction training, working together to identify issues and develop feasible solutions. This approach ensured that the training did not disrupt service delivery as only one or two people per department and function participated per training.
- Using participatory approaches to learning and behavior change were critical for creating ownership of the response. They created a safe and fun space to discuss difficult issues while finding new and creative ways to communicate about "old" issues, like HIV transmission.
- Creating new opportunities for contact between clients living with HIV or who are members of key populations and health facility staff outside the dynamic of the provider-client relationship helped breakdown misconceptions, fear, and stereotypes. This was done through client trainers and panel discussions.

Evaluation Methods

Representative baseline (n=717 females/432 males; August 2017) and endline (n=778 females/371 males; April 2018) surveys capturing stigma drivers and manifestations among health facility staff. The study team:

- Matched five intervention facilities with five comparison facilities in Ashanti, Brong Ahafo, Eastern, Greater Accra, and Western regions for a total of 10 high-HIV-caseload facilities.
- Collected endline data six months after starting the still-ongoing intervention.
- Estimated before-after trends and difference-in-differences by fitting generalized linear models with identity link functions and binomial error distributions. Standard errors were clustered by facility.

Results

There were statistically significant before-after improvements in most outcome domains in the intervention facilities (Table 1/Figure 1), and smaller improvements in comparison facilities. More significant changes were observed in the fear of transmission driver and resulting stigmatizing avoidance behaviors than stigmatizing attitudes.

- We observed statistically significant difference-in-differences in reductions in unnecessary fear (23.9%; p<0.001), stigmatizing avoidance behaviors (15.7%; p=0.011), and preference not to treat men who have sex with men (14.2%; p=0.001).
- Staff from the intervention facilities were 21.5% (p=0.019) more likely to report that behavior toward patients was much better at follow-up than staff at the comparison facilities.

"Since the training we have seen a sharp increase in MSM living with HIV coming for services. We think this is mostly due to the change in our staff and how they interact with key populations. We also see MSM coming freely for their medicines during regular facility hours. Before they preferred to come after hours to avoid seeing many staff."

– Champion team member and ART clinic staff

Figure 1. Changes in Fear, Care Willingness, and Knowledge of Policy

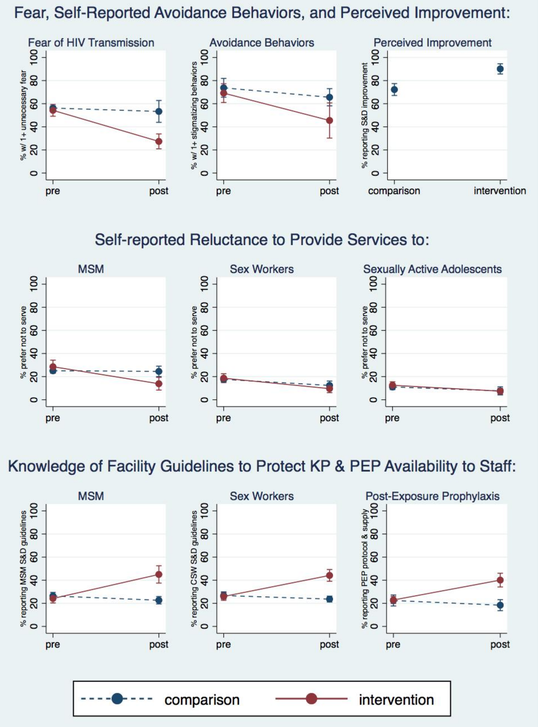

Table 1. Selected Difference-in-Differences Results: Difference in Change Pre-post Data Collection

Comparing Intervention (n=1,198) to Comparison (n=1,110) Health Facilities

Stigma and discrimination indicator	% difference in change between intervention and comparison facilities in non-stigmatizing direction	Significance (P-value)	95% Confidence Interval
Fear of HIV transmission during routine care for people living with HIV			
Touching clothing of a client living with HIV (n= 1,848)	11.25%	0.037	7.0, 21.8
Dressing wounds of a client living with HIV (n=1,513)	18.92%	0.001	7.46, 30.39
Drawing blood from a client living with HIV (n=1,588)	23.29%	<0.001	14.53, 32.04
Taking the temperature of a client living with HIV (n=1,613)	6.7%	0.184	-3.21, 16.67
Composite: at least one of the above (n=1,958)	***23.86%***	***<0.001***	***10.69, 37.04***
Routinely engaging in unnecessary and stigmatizing avoidance behaviors with clients living with HIV			
Avoid physical contact (n=1,827)	1.7%	0.367	-2.0, 5.42
Wear double gloves (n=1,673)	16.73%	0.001	6.90, 26.56
Wear gloves during all aspects of the patient's care (n=1,698)	4.2%	0.320	-3.92, 11.97
Use extra precautionary measures only with clients living with HIV (n=1,678)	24.67%	<0.001	17.46, 31.88
Composite: usually engage in at least one of the avoidance behaviors (n=1,940)	***15.65%***	***0.011***	***3.61, 27.70***
Own preference to not treat key populations			
Men who have sex with men (n= 2,275)	14.2%	0.001	5.71, 22.59
Sex workers (n= 2,274)	3.8%	0.238	-2.51, 10.08

*Some variables were reverse-coded in the survey. When presenting results, we inverted them so that a positive difference-in-differences is consistently an improvement in stigma and discrimination. N's vary due to missing values or because a question was non-applicable to some category of staff.

"This is unlike any training we have experienced before. It made us constantly participate and discuss with our co-workers and explained things (e.g., HIV transmission) in a way we could all understand."

– Champion team member and ART clinic staff

Conclusions

Stigma and discrimination-reduction interventions targeting the whole facility are feasible, welcomed, and stimuli for change in a short timeframe (six months). Facility management and staff noted that the benefits of the intervention went beyond HIV stigma-reduction to support an overall improvement in quality of care and provider-client interactions. The whole-facility approach to stigma and discrimination reduction in health facilities should be scaled up to improve quality of care and ensure equitable access to services for all clients.

Acknowledgements

This work would not have been possible without the partnerships between the Ghana AIDS Commission (GAC), the National AIDS Control Program (NACP), The Educational Assessment Research Center (EARC) and HP+ and the generous joint funding support from the United States Agency for International Development (USAID) and the President's Emergency Fund for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). We gratefully acknowledge the time and insights provided by all respondents and the data collection and entry teams in Ghana.

Partnered With

USAID FROM THE AMERICAN PEOPLE · The Global Fund To Fight AIDS, Tuberculosis and Malaria · HP+ HEALTH POLICY PLUS

HP+ (No. AID-OAA-A-15-00051) is made possible by the generous support of the American people through the President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID). The contents do not necessarily reflect the view of PEPFAR, USAID, or the United States Government.

15 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS